STAIRWAYS BEHAVIORAL HEALTH OUTPATIENT CLINIC

PSYCHIATRIC EXAM AND EVALUATION

PATIENT NAME: Ann Weber
DATE: January 11, 2007
BSU: 25215602
DATE OF BIRTH: September 7, 1954

DEMOGRAPHICS: Ann Weber is a 52-year-old, single, Caucasian female, who resides alone. The patient reportedly is currently unemployed.

HISTORY OF PRESENT ILLNESS: The history is reported by the patient herself and from records from Stairways Behavioral Health. This patient is a 52-year-old female, with significant history of cocaine addiction and consequent legal problems. This patient is also noted to have extensive history of unstable mood. The patient says that her mood has been a chronic problem for her for most of her life. She says that her mood has tendency to swing up and down rapidly and unpredictably. She says that her energy level also fluctuates rapidly from one extreme to another. The patient says that she rapidly cycles between manic episodes and depressive episodes. During manic episodes, she reportedly has very high energy level, very high activity level, extreme impulsivity and reckless and erratic behavior. During depressive episodes, she reportedly has dysphoric mood, anhedonia, poor energy level, and feelings of hopelessness, helplessness and worthlessness. The patient says that sometimes she also has had auditory hallucinations, including hearing voices in her head that call her name. She also reports having problems, at times, with paranoid ideation.

CURRENT MEDICATIONS: The patient says that she is supposed to be on Prozac and trazodone, but she says that she has not taken those medications recently because of financial and insurance problems.

PAST PSYCHIATRIC HISTORY: This patient is noted to have extensive history of psychiatric treatment, including multiple hospitalizations. She says that hospitalizations have been at St. Vincent's Hospital and at Millcreek Community Hospital. She says that hospitalizations had occurred because of suicidal threats and suicidal gestures. The patient says that she has tried many medications during hospitalizations, but she indicates that she has been noncompliant with outpatient followup and the patient blames this on financial and insurance problems.

RISK ASSESSMENT: The patient reports having passive thoughts, at times, of not wanting to live. However, she denies any current, active suicidal plan or intention. She denies having homicidal ideation. The patient says that in the past she has made suicidal gestures, including cutting herself. She denies having been physically assaultive towards others. (Continued page 1 of 3)

DEFENDANTS EXHIBIT 1

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PSYCHOSOCIAL HISTORY: Family: The patient says that during childhood she was raised by her grandmother for much of the time, but then later moved back into her mother's home. The patient says that while she lived with her mother, her mother had many different boyfriends who each lived with them momentarily. The patient claims to have been physically abused by her mother and sexually abused by some of her mother's boyfriends during childhood. The patient says that she has two sisters and also had one brother. The patient says that her mother and her brother died in a house fire in May 2005. The patient says that her father was not involved in her upbringing, or in her life in any way. The patient says that one of her sisters received psychiatric treatment at Stairways Behavioral Health. The patient says that she believes that all of her family members might have had bipolar disorder, but she says that most of her family members have not sought treatment for this.

Marital History: The patient says that she has never been legally married. However, she says that she had a long-term relationship in the past that lasted many years, which she considered to be a, "common-law marriage." The patient says that she has a 34-year-old daughter and an 18-year-old son. She says that her son was the product of her past, "common-law," relationship, but her daughter was the product of another previous relationship.

Education: The patient says that she graduated from high school and went to college for three years. She denies having a college degree.

MILITARY: The patient denies any military history.

EMPLOYMENT: The patient says that she has recently been unemployed. She says that she worked as a state caseworker for over 20 years, but then was fired from her job because of a criminal conviction.

CRIMINAL JUSTICE: The patient says that she currently is on parole after having served time in prison for a number of offenses including money laundering and possession and distribution of illegal drugs. The patient says that she has another court hearing a few days from now, during which she expects to be sent back to prison. She says that this is because of a parole violation. Specifically, the patient says that she relapsed on cocaine and had two positive urine tests for this.

SUBSTANCE ABUSE HISTORY: This patient is noted to have history of problems with cocaine. The patient says that the last time she used cocaine was in November 2006. She indicates that she used to heavily abuse cocaine on a very frequent, if not daily basis. The patient is vague about revealing further details. The patient admits to having a, "drug problem," in regards to cocaine. The patient denies having abused substances other than cocaine. (Continued page 2 of 3)

MEDICAL HISTORY: The patient denies any known physical medical problems. She denies any known drug allergies

MENTAL STATUS EXAM: On mental status examination the patient is found to be awake and alert. She is oriented to person, place, and time. Her speech is coherent and goal-directed, but often pressured. Her mood is, "Not good." Her affect is labile and irritable and sometimes dysphoric and tearful. She reports having passive thoughts, at times, of not wanting to live. She denies any current active suicidal plan or intention. She denies having homicidal ideations. She reports having occasional auditory hallucinations, including hearing voices in her head. She also reports having paranoid ideations, at times. Her long-term and short-term memory appear to be generally intact. Her intelligence appears to be around average. Her insight and judgment appear to be very questionable by history.

DIAGNOSES:

Axis I:	Mood disorder not otherwise specified. Rule out bipolar disorder with psychotic features. Cocaine dependence.
Axis II:	Deferred.
Axis III:	The patient denies having physical medical problems.
Axis IV:	Legal problems; family and social stressors; alleged past history of abuse.
Axis V:	Current global assessment of functioning 45.

TREATMENT RECOMMENDATIONS: At this time Prozac is being restarted to help treat her depression. Also, Seroquel is being started to help treat her mood instability and psychotic symptoms. The therapeutic and side-effects of these and other medications were discussed with the patient and the patient is currently agreeable with this plan. The patient is to have continued outpatient psychiatric treatment through Stairways Behavioral Health.

Sean Su, MD

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